Long Island Mental Health Housing Application

PPC, Building 72-2

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Brentwood, NY 11717

(631) 231- 3562

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Long Island Mental Health Housing Application

Revised 9/03-TAP

Applicant's Name (Please Print clearly): **SS#:**

INSTRUCTIONS

Completed applications **MUST** include:

- ☐ Psychosocial History
- ☐ Psychiatric Summary (including current clinical assessment signed off by a licensed Psychiatrist)
- ☐ Recent Physical Exam (including PPD exam within 1 year of application date signed off by licensed physician)
- ☐ Physician's Authorization Form (licensed: Supervised and Apartment Treatment only)
- ☐ Completed Housing Preference Form.

Any omissions will delay potential placement.

Please indicate the program for which you would like to be considered (please see summary):

(check A, B, and /or C)

___ A. Supervised Community Residence
___ B. Apartment Treatment A
___ C. Apartment Treatment B
___ D. Supported Housing

Please check any specific program you would be appropriate for (see summary for details)

___ M.I.
___ M.I. / M.R.
___ Senior Citizens / Geriatric (Nassau Only-Over 55)
___ MICA
___ SOCR
___ RCCA (Suffolk Only)
___ Young Adult (Ages 18-25)
___ Family Housing (Supported Housing Only)
___ Couples (Supported Housing Only)
Specify other individual:_____
(May require addition application for other individual)
___ HUD – Homeless Housing
___ HIV / AIDS Housing (requires additional consent)
___ CR-SRO_____

Agency Preference (if any): _____
_____

Geographic Preference (if any): _____
_____

☐ Please check here if the applicant is **not** interested in services of the Peer Specialist Team. In the event the above is not checked the Housing Preferences Form will be forwarded to the Peer Specialist Team.

I agree with this referral and give my consent for information about myself to be shared with agencies in connection with my referral to a housing program. I also agree that all the information contained herein is accurate to the best of my knowledge and is reflective of my current situation. See consent form.

Current Contact Info: (_____)_____

_____ _____
Date Signature of Applicant **(Required)**

_____
Signature of Witness

Summary

Program descriptions

The following programs are operated by private, not-for-profit organizations licensed by the New York State Office of Mental Health. The programs are supervised by trained professionals who are available (via beeper or telephone) as needed in addition to regularly scheduled on-site hours. Residents are offered Restorative Services and are trained in the following areas:

Assertiveness / Self-Advocacy Training; Community Integration / Resource Development; Daily Living Skills; Health Services; Medication Management / Training; Parent Training; Rehabilitative Counseling; Skill Development; Socialization; Substance Abuse Services; Symptom Management

These programs are considered transitional housing. Individuals applying for Senior Citizen / Geriatric CRs (Nassau Only) must be 55 and over. Individuals applying for placement in MI/MR housing must fall between 65 – 85 IQ. There are three levels of care under the title Community Residence Program:

Supervised CR (Licensed):
These programs are supervised 24 hours per day. Overnight staff members are available. These residences typically house 8 – 12 individuals in one large house. Residents are offered all restorative services (listed above), generally with an emphasis on Daily Living Skills such as cooking, cleaning, personal hygiene, food shopping and money management. Medication is supervised as needed.

State Operated Community Residence (SOCR) (Licensed):
This level houses between 10-24 residents, staffed 24 hours a day. Clients are involved in meal planning, shopping, cooking and clean up. Services are same as above.

Residential Care Center for Adults (RCCA) (Licensed) Suffolk Only:
RCCA is a structured environment. This level houses 130 residents, staffed 24 hours a day, meals and social activities are provided. Medication is monitored by staff.

Apartment Treatment A and B (Licensed):
These programs typically receive staff visits from 5 – 7 (A) times per week to 1 – 4 (B) times per week. There are generally 2 – 3 residents per house or apartment. Residents are expected to have good daily living skills, and be able to hold their own medication. Food is not provided. Instead, residents receive an allowance, which is used to purchase food and cleaning supplies

Supported Housing:
Supported Housing programs vary. Programs may offer individual bedrooms or multiple person sites as well as family housing. Individuals residing in Supported Housing pay 30% of their monthly income toward their rent. The rest of their rent is subsidized. Residents of these programs live fairly independently, and may receive visits 1- 4 times monthly. Supported Housing is considered long term housing.

Homeless Housing:
All homeless programs are subject to the HUD definition of homelessness as there are different regulations for homeless housing.

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Section A: Identifying Information: (*Please print clearly*)

1. First Name: _____ Last Name: _____
2. AKA: _____
3. Date of Birth: _____/_____/_____ (age: _____)
4. Social Security #: _____ - _____ - _____
5. Gender: ( ) Male ( ) Female
6. Current Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Domestic Partner
7. Homeless? ( ) Yes ( ) No If Yes, check type: ( ) Currently ( ) Pending ( )other (Please use page 6 to explain)
8. Address: (if applicant is homeless, indicate location. If applicant is hospitalized, list address / location prior to hospitalization on A side. If applicant currently lives in a Mental Health Facility list address and info on B side.)
   (A) Street: _____Apt. # _____
   City: _____State: _____ Zip Code: _____
   Phone #: (_____)_____
   (B) Agency Name: _____
   Street: _____ Apt. #_____
   City: _____State: _____ Zip Code: _____
   Phone #: (_____)_____
9. Emergency Contact Name: _____
   Address: Street: _____ Apt. #_____
   City: _____State: _____Zip Code: _____
   Phone #: (_____)_____

Number of Children to be housed: _____ Age(s) and Sex: _____

Special Conditions: _____

**10. Applicant's Ethnicity: _____

Citizenship: ( ) USA ( ) Other

If other, specify: _____

11. Is the applicant a Veteran? ( ) Yes ( ) No
    Type of Discharge?_____

12. List all Entitlements and income which the applicant receives or which are pending:

	Monthly Dollar ($) Amount	**ID Number or "P" for Pending**
( ) Social Security		
( ) SSI		
( ) SSD		
( ) PA		
( ) Veterans		
( ) Medicare		
( ) Medicaid		
( ) Food Stamps		
( ) Pension		
( ) Wages		
( ) Worker's Comp		
( ) Unemployment		
( ) Other		

Does the applicant have a Representative Payee? ( ) Yes ( ) No

If yes: Name:_____

Phone:(_____)_____

Is the applicant paying an overpayment? ( ) Yes ( ) No

How much?_____ To what agency?_____

13. Is the applicant currently receiving or eligible for any of the following?

CSS:
Contact Person: _____ Phone :(_____)_____ ( )Yes ( )No ( ) Pending

CSS Waiver:
Contact Person: _____ Phone: (_____)_____ ( )Yes ( )No ( ) Pending

ICM:
Contact Person: _____ Phone :(_____)_____ ( )Yes ( )No ( ) Pending

AOT:
Contact Person: _____ Phone :(_____)_____ ( )Yes ( )No ( ) Pending

AOT Service Enhancement (Diversion):
Contact Person: _____ Phone: (_____)_____ ( )Yes ( )No ( ) Pending

ACT:
Contact Person: _____ Phone :(_____)_____ ( )Yes ( )No ( ) Pending

***This question is asked for statistical purposes only. Applicants will not be discriminated against based on race, color, creed, religion, sex, national origin, age, familial status, handicap, or sexual preference.*

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Applicant Name (Please print clearly): SS#:

Section B: Housing, Employment and Education History & Preferences

1. Please list where the applicant has resided for the past five years and detail any history of homelessness. Include shelters, drop-in centers, streets, hospitals, prison, supportive residences, SRO's, family and independent housing (please start with most recent location):

Dates	Location	Reason for Leaving

2. Has applicant been employed during the last five years?
( ) Yes ( ) No ( ) Unknown
If yes, please list dates and positions:

Dates	Position / Title / Type of Employment

3. Educational / Training History (*check all relevant items*):
- ( ) Special Education
- ( ) Some High School
- ( ) H.S. Diploma or GED
- ( ) Some College
- ( ) College Degree
- ( ) Master's Degree or higher
- ( ) Vocational Training, Trade: _____
- ( ) VESID Sponsorship: _____

4. **What is the reason this referral is being made at this time? (Please answer on page 5).**

Section C: Skills / Supports Assessment

1. Rate the degree to which the applicant can accomplish the following: (**1**=Cannot accomplish, **2**=Accomplish with assistance, **3**=Can accomplish independently, **U**=Unknown):

	1	2	3	U
Paying Rent	( )	( )	( )	( )
Housekeeping	( )	( )	( )	( )
Money Management	( )	( )	( )	( )
Program Participation	( )	( )	( )	( )
Use kitchen appliances safely	( )	( )	( )	( )
Use of leisure time	( )	( )	( )	( )
Communicate in non-threatening manner	( )	( )	( )	( )
Travel	( )	( )	( )	( )
Access and use of medical services	( )	( )	( )	( )
Prepare or obtain meals	( )	( )	( )	( )
Obtain food	( )	( )	( )	( )
Securing / Maintaining Benefits	( )	( )	( )	( )
Manage medication regimen	( )	( )	( )	( )
Maintain personal hygiene	( )	( )	( )	( )
Smoke safely (if applicable)	( )	( )	( )	( )
Manage symptoms	( )	( )	( )	( )
Refrain from substance abuse	( )	( )	( )	( )

2. Indicate all services the applicant regularly utilizes:

Program Name	Contact	Phone

3. Indicate all support services needed once the applicant is housed:

Health	( )
Educational Program	( )
MICA (Dual Dx) Day Program	( )
MIMR	( )
Psychiatric Day Program	( )
Therapy	( )
Clubhouse	( )
Psychiatric Clinic / Psychiatrist	( )
Alcohol / Drug Treatment Services	( )
Alcoholics / Narcotics Anonymous	( )
Vocational Program	( )
On-site Case Management Services	( )
Probation / Parole	( )
Cognitive Rehab	( )
None	( )
Other:_____	( )

Long Island Mental Health Housing Application

Applicant Name (Please Print Clearly): SS#:

Section D: Psychiatric Information

1. Current Diagnosis (*Include ALL Axis I and Axis II diagnoses and Diagnostic and Statistical Manual (DSM-IV) Codes:*

Axis I: _____
_____
_____
Axis II: _____
_____
_____
Axis III: _____
Axis IV: _____
Axis V: _____

If available IQ test used:_____
Score: _____ Date: _____
Psychiatrist's Name: _____
Address: _____
Phone: (____)_____

2. Does the applicant have a history of, or is the applicant currently exhibiting any of the following?
(*Fill in all items:* **C** = Current, **H** = history, both **C** and **H** if appropriate, **N** = Neither, or **U** = Unknown.)

	C	H	N	U
Homicidal ideas / attempts	( )	( )	( )	( )
Delusions	( )	( )	( )	( )
Hallucinations	( )	( )	( )	( )
Disruptive Behavior	( )	( )	( )	( )
Severe Depression	( )	( )	( )	( )
Highly disorganized thought processes	( )	( )	( )	( )
Criminal Activities / Arrests	( )	( )	( )	( )
Cognitive Impairment	( )	( )	( )	( )
Aggressive / Assaultiveness	( )	( )	( )	( )
Suicidal ideas / attempts	( )	( )	( )	( )
Arson / Firesetting	( )	( )	( )	( )
Sexual acting out	( )	( )	( )	( )
Compulsive behaviors	( )	( )	( )	( )
Inappropriate touching	( )	( )	( )	( )
Substance / alcohol abuse	( )	( )	( )	( )

3. Current Psychotropic Medications:

Name	Dosage	Schedule

4. What level of support does the applicant require to achieve medication compliance?
( ) None, independent
( ) Supervision ( ) Refuses / Non-compliant
( ) Reminders ( ) Not Applicable

5. Is the applicant currently hospitalized? ( ) Yes ( ) No
If so, Date of admission: _____
Hospital name and ward: _____
Contact Person: _____
Phone: (_____)_____

6. To the degree known, list all psychiatric hospitalizations and psychiatric emergency room use:

Hospital / ER	Adm. Date	Dis. Date	Reason

Total length of time hospitalized: _____

7. Does the applicant have a history of substance abuse?
( ) Yes Substance(s): _____
_____
_____
_____

Frequency of use:
( ) Daily ( ) Less than once a week
( ) Several times / week ( ) Not Applicable
( ) Once weekly ( ) Unknown

( ) No

8. Does the applicant have a history of substance abuse treatment?
( ) Yes ( ) No

Name of Treatment Program	Date

Length of time the applicant has spent substance free:
Alcohol: since ____ / ____ ( ) Not applicable
Drugs: since ____ / ____ ( ) Not applicable

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Applicant Name (Please print clearly): SS#:

Section E: Medical Information

The disclosure of HIV-Related Information is not required, but if the applicant wishes to release it, this form must include a special consent to Release Information Form signed by the applicant. This is to be added as page 7.

1. Medical Diagnosis: (*Include ALL Axis III Diagnoses*):

_____
_____
_____
_____

Allergies: _____

2. Current non-psychotropic medications:

Name	Dosage	Schedule

3. To the degree known, list all medical hospitalizations during the past *three* years:

Hospital	Adm. Date	Dis. Date	Chief Complaint

4. Physical Functioning Level (*Answer each of the following*):

	Yes	No
Fully Ambulatory	( )	( )
Climbs one flight of stairs	( )	( )
Bedridden	( )	( )
Wheelchair Required	( )	( )
Amputee	( )	( )
Blind	( )	( )
Deaf	( )	( )
Mute	( )	( )
Incontinent	( )	( )
Needs help with toileting	( )	( )
Can fully bathe self	( )	( )
Can feed self	( )	( )
Can dress self	( )	( )

Does the applicant have a medical condition that requires special services? ( ) Yes ( ) No

If so, indicate which services:

( ) Special medical equipment
Please Specify:_____
( ) Medical supplies
Please Specify:_____
( ) Ongoing physician support
( ) Nursing services
( ) Home Care
( ) Therapeutic diet
( ) Injectable medication
( ) Other _____

What medical services is the applicant currently receiving?

_____
_____

Name, address, and telephone number of treating physician:

_____
_____
_____
_____

Does applicant have pets? ** ( ) Yes ( ) No
If yes, please specify_____
**Please be aware that different programs have varying policies regarding pet ownership. In addition, pets may affect your entry into mental health housing.

Is the applicant allergic to animals? ( ) Yes ( ) No
If yes, please specify _____

Does applicant smoke cigarettes? ( ) Yes ( ) No

Does applicant have any additional challenges or issues that may impact placement into mental health housing?

_____
_____
_____
_____
_____
_____
_____

Long Island Mental Health Housing Application

Applicant Name (Please print clearly): _____ SS#: _____

What is the reason this referral is being made at this time?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Referring Agency: _____

Address: (Street)_____ (City)_____ (State)_____ (Zip)_____

Facility / Agency Type:_____

Referring Worker :
I also attest that all the information contained herein is accurate to the best of my knowledge and is reflective of the applicant's current situation.

Worker Name ***(Please Print Clearly)***_____

Title: _____

Phone: (_____)_____FAX: (_____)_____

Please be certain the following information has been included with and in addition to this application before signing:

- ☐ **Signature of Applicant (Required)**
- ☐ **Psychosocial History**
- ☐ **Psychiatric Summary (including current clinical assessment signed off by a licensed Psychiatrist)**
- ☐ **Recent Physical Exam (including PPD within 1 year of application date signed off by licensed physician)**
- ☐ **Physician's Authorization Form (Licensed programs only: Supervised and Apartment Treatment only)**
- ☐ **Completed Housing Preference Form.**

Referral Signature: _____ Date:_____

AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

□ Initial Authorization

□ Semi-Annual Authorization

□ Annual Authorization

Client's Name: _____

Client's Medicaid Number: _____

ICD.9 Diagnosis: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, have Determined that _____ would benefit from provision of mental health
(Client's name)

Restorative services defined pursuant to Part 593 of 14 NYCRR. This determination is in effect for the Period_____to_____at which time there will be an evaluation for Continued stay.

_____/_____/_____ _____ _____
Month Day Year Name (Please Print) Licensure#

_____
Signature

□ Check here if client is enrolled in Managed Care (e.g., an HMO or Managed Care coordinator Program) and enter primary care physician name and managed care provider identification number.

_____ _____
Physician Managed Care Provider ID #

HOUSING PREFERENCES FORM

Date_____

Applicant Name:_____ SS#_____

The applicant should fill out this form with assistance, if necessary. The questions are intended to clarify the applicant's housing preferences. The applicant specifies his/her preferences today, assuming these may change over time.

This information will be shared with SPA Team to help identify your interests. Please note this does not guarantee your preference will be satisfied.

1. Do you have a particular town or area you would like to live in.

   1st Preference_____

   2nd Preference_____

2. Please circle Yes or No in response to the following:

   Would you like assistance with learning how to:

A>prepare your own meals?	YES NO
B>manage your money?	YES NO
C>take your medication as prescribed?	YES NO
D>improve personal hygiene skills?	YES NO
E>travel (use bus, train, etc.)?	YES NO
F>keeping personal area clean?	YES NO
G>do your own laundry?	YES NO
H>do anything else specifically?	YES NO

_____

_____

01/04

3. In addition to your Service Plan, are you interested in:

   >A Community Based Alternative Treatment Program: YES NO

   (Clubhouse Model Program, Psycho-social Program, School, or Vocational Training)_____

   >Employment or Employment Readiness Program? YES NO

   >Housing Agency Consumer Council involvement? YES NO

   >Other?: Please specify:_____

4. Are you interested in participating in social or recreational activities sponsored by the housing agency? YES NO

5. Do you require handicap accessible housing? YES NO

   Please specify: _____

_____

6. What other services are you seeking? (Self-Help, AA, NA, EA, Double Trouble, Social, etc.) Please specify:_____

7. Is there anything else you would like the committee to know about you?

   _____

   _____